Administration Role

- *Antipsychotic dose reduction can not succeed without full buy in by administration (Admin and DON)*
- *Facility needs to be prepared to manage patients non-pharmaceutically, beyond the QI meetings*
- *Facility needs to expect and be tolerant of a few bad days for a few patients*
- *Facility should be always in search of non-pharmaceutical interventions tailor made for specific residents*

- *Minimizing ER visits and transfers for "behaviors" requires admin buy in. "When in doubt ship them out" may still be a tempting approach.*

- *Working on unit structures and staffing structure (not necessarily numbers). This has dual benefit in combined SNF-NF facilities, as SNF patients don't like being exposed to dementia patients with behaviors, and the extra stimulation of SNF unit can exacerbate behaviors in NF patients*

- *Changing meal time structure (more on that in Nick's lecture)*

Nursing Principles

- *A call or on-site request for management of difficult behaviors should NOT start with a drug request*
- *The goal is to develop a better plan of care with the help of the providers*
- *Recommendations for drugs from nursing staff is discouraged*
- *Baseline behaviors that don't constitute a pre-crisis or crisis situation should be handled by day team and not on-call*

What Happens When Staff Are Tempted To Do It The Old Fashion Way?

- *Does the unit manager follow up with a nurse who requested drugs over night when the situation didn't warrant it?*

- *Does the DON follow up with the unit managers and nurses directly when such cases occur?*

- *Is everyone reviewing the case also reviewing provider notes and talking to providers at every step of the process?*

At The End Of The Day If Evening Shifts And The CNAs Are Not Getting It, This Project Won't Succeed

Nursing Inservices

- *Structured Education around appropriate and inappropriate use of antipsychotics in Dementia patients*
- *Follow up education sessions to discuss specific cases as learning opportunities to point out successes and failures*
- *Convincing the nursing staff that reducing antipsychotic use in dementia patients is consistent with best practices in Geriatric Medicine. Nurses can be a great advocates, once they buy in.*
- *Avoiding justification of high antipsychotic use based on population mix.*

Nursing

- *Pre-crisis interventions*
- *Proper documentation (starting with consent) around antipsychotics to help guide treatments and future dose reductions*
- *Avoiding HS and weekend calls for dementia related behaviors except for crisis and pre-crisis patients*
- *Feedback to nursing when routine medication changes are made using the on-call system. This should involve the DON and Admin.*

Nursing

- *You know you're making sustainable progress when nurses buy in to asking providers for dose reduction on stable patients or when behaviors are treatable with nonpharmacutical interventions. Often times nurses are the first to notice when the anti-psychotics have had no positive contribution to the care, i.e. when residents are hard to manage before and after the meds.*

CNAs

- *CNAs won't buy in if Nurses are not on board*
- *A dose reduction can be Hardest for CNAs if there is no specific changes to the care plan*
- *Adjusting Care time, like showers, may negatively impact the CNAs work*
- *More training in Dementia care and non-pharmaceutical interventions*
- *Based on importance, this section should have been the first slide*

- *If we didn't teach anything else we should at least teach that:*
  - *Speed of care impacts residents behavior. Sometimes all it takes is for the CNAs to slow down*
  - *There are many ways to stay safe and avoid injury caused by dementia residents. Every time there is an incident involving a CNA being hit or bitten by a resident we should revisit the approach even when it involves our best staff.*
  - *We can't joke and use first names when dealing with sexually inappropriate and disinhibited residents*

Case 1

- *81 YOWM Bipolar, PTSD, Alzheimer's with delirium. 2 to Lithium*
- *Multiple ER visits before final admission then SNF*
- *Physical with staff*

Case 2

- *78 YOWM with vascular dementia, ex-truck driver, Anger and agitation around care and during daily routines*

- *Psych admission times one, antipsychotics tapered off after 6 months of stability and due to presence of EPS, Depakote used as primary drug to manage his anger and short fuse.*

- *Called after hours out of the blue to use topical risperdal to calm him down. It only takes one call to undo months of work!*

Case 3

- *86 YOWF with Severe Alzheimer's Dementia in a wheelchair, and behaviors limited to wondering and approaching residents and pulling on everything*

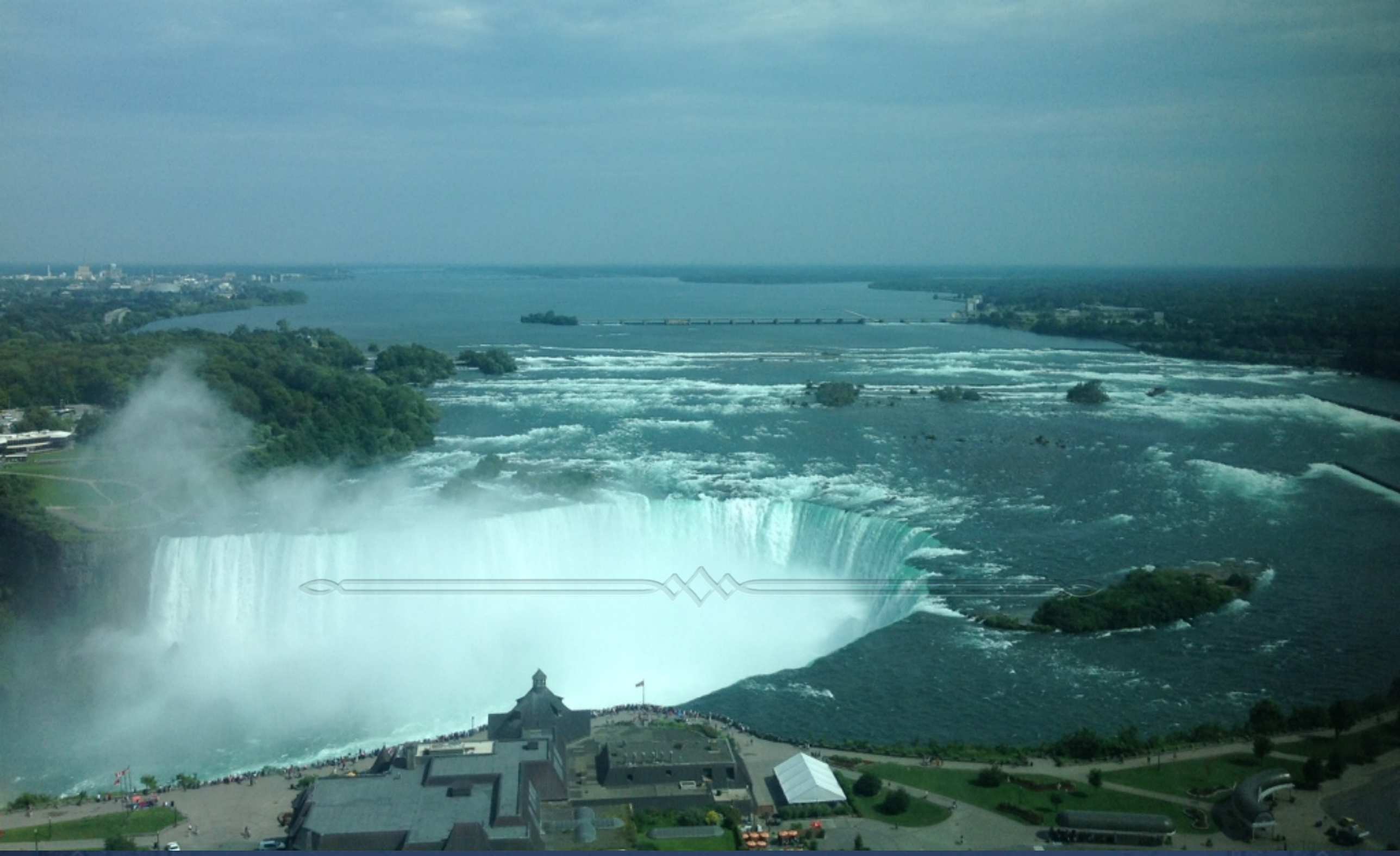
- *Seroquel (Quetipine) started by a provider upon request from unit manager due to patient constantly pulling on table cloths that were new to the unit.*

- *DON contacts me the next day to review the case.*

- *Circumstances of the order reviewed with provider and unit manager.*

Case 4

- *82 YOWF with Severe Alz Dementia with Depression. Still mobile, Prior Psych Hospitalization for behaviors.*
- *6 months out she tolerated a taper and eventual DC of Antipsychotics*
- *Doing well with no Psychosis. Confused, wants to go home and asks family to take her home every chance she gets. Bahaviors worse after her weekly visit home*
- *Family insists on Giving her antipsychotics even months after being stable without them.*



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